

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

Type of Requestor: (X ) HCP ( ) IE ( ) IC	Response Timely Filed? (X ) Yes ( ) No
Requestor  AHC on Behalf of UHS-McAllen Medical Center 10002 Battlevue Pkwy. Manassas, VA 20109	MDR Tracking No.: M4-03-4528-01
	TWCC No.:
	Injured Employee's Name:
Respondent  Texas Mutual Insurance Co. Rep. Box # 54	Date of Injury:
	Employer's Name: Valley Caliche Products, Inc.
	Insurance Carrier's No.: 99A0000268365

## PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6-3-02	6-10-02	Inpatient Hospitalization	\$86,827.48	\$0.00

## PART III: REQUESTOR'S POSITION SUMMARY

Claim should be paid at 75% F &R per state guidelines.

## PART IV: RESPONDENT'S POSITION SUMMARY

The carrier maintains the right to audit hospital charges as provided for by TWCC Rule 133.301, 134.401, 134.600, 133.206. Section 413.011(b) of the Texas Labor Code mandates that the "Guideline for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

The operative report indicates the claimant underwent, Lumbar laminectomy, decompression, fasciectomy, L4/5. Lumbar laminectomy, discectomy at L5/S1. Posterolateral fusion, L4/5, S1; Posterior segmental instrumentation and interbody fusion.

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 7days (consisting of 7days for surgical). The requestor failed to obtain preauthorization for the additional four dates; therefore, reimbursement for the initial three days is allowed. Accordingly, the standard per diem amount due for this admission is equal to \$3354.00 (3 times \$1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows:

Regeneration Technologies, Inc. invoice of \$7200.00 + 10% = \$7920.00.

TOTAL of Invoices = \$7920.00.

TOTAL of Invoices and Per Diem/ Surgery \$7920.00 + \$3354.00 = \$11,274.00

The insurance carrier paid \$11379.77 for the inpatient hospitalization.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

#### PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

Elizabeth Pickle

04-04-05

Authorized Signature

Typed Name

Date of Order

#### PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

#### PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_